Magazine of Ambulatory and Primary Care

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A Publication of the Primary and Ambulatory Care Strategic Healthcare Group

Message from the Office of Primary and Ambulatory Care

By W. Mark Stanton, MD, MHS, *Chief Consultant, Primary and Ambulatory Care Strategic Healthcare Group, located at VA Central Office, Washington, DC*

"Looking Ahead"

Even though we are all living and operating under the Continuing Resolution (CR), we continue to plan for future educational activities.

Working with Dr. Rivkah Lindenfeld, Clinical Product Line Manager at the Northport EERC, some tentative plans have been developed for FY 03. The following are activities that have been conceptually approved (no funding, because of the CR) but recognized as being important and adding value to our goal of producing the optimally healthy satisfied veteran.

1. Integrated Ambulatory Care conference: Not to exceed 250 participants (including faculty). Vision: A full team representing each VISN including a Clinical Manager or a VISN Director. (This proposal has been submitted but we would have to obtain approval from the Deputy Secretary, Dr. Mackay). The field representative would be the resource nucleus for the VISN. The focus will be on Waits/Delays and Advanced Clinical Access." Anticipated follow-up: FY 04 development of a cluster of VISN programs.

2. Practice Management "Train -The -Trainer Workshop" : Participants would include Consultants and active Clinic Managers. Vision: The issue of Waits/Delays and Advanced Clinical Access would be discussed. The final group of participants will include a multi-disciplinary representation from the Primary Care Consultants Group (PCCG) and in addition a similar group of individuals versed in issues of Waits/Delays as well as Advanced Clinical Access. It is anticipated that there would be a maximum of 25-30 participants.

(*Continued on page 2*)

PAGES- INSIDE THIS ISSUE

(Continued from page 1)

This Workshop would enhance information exchange while identifying practice management tools. The knowledge gained will provide a common understanding between the Clinic Managers and the members of the PCCG. This shared knowledge base will facilitate improvements in Clinic Practice Management.

3. Practice Management Guide (formerly Clinic Management Guide): Vision: A publication prepared as a follow-up to the initial CMI Guide that was distributed and well received at the National Conference held in San Diego. The Guide is currently being updated, additional chapters are being added and edited.

4. Mini Residency Primary Care: Vision: A focus on integrating Mental Health Services within the primary care model. Focus of this mini residency is to promote and improve integration of Mental Health & Primary Care. This program was initiated in FY 99 and based on feedback was judged to be excellent.

Planning committees, including field, VACO and EES representatives will be established for each of the above activities. Curriculum will be developed. Faculty will be identified and anticipated logistics and follow-up will be discussed. We will keep you informed as the approval and budgeting processes evolve.

Tune into the Primary Care Conference calls to hear what is happening. The next scheduled call is December 18th @ 1 p.m., ET. Calls are scheduled for the third Wednesday of each month @ 1 p.m. ET starting January 15, 2003. For all calls, the dial in number is 1-800-767-1750; the access code is 28907. (See listing on page 9.)

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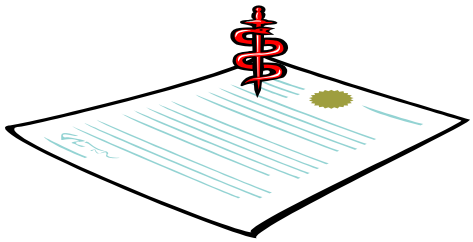
HealthierUS Initiative

By Steven Yevich, MD

Director, VA National Center for Health Promotion and Disease Prevention (NCHP) Durham, NC



President Bush launched a new HealthierUS initiative June 20, 2002, with an aim to encourage Americans to improve their quality of life by living healthier. The HealthierUS initiative is intended to encourage all Americans to: Be physically active every day; Eat a nutritious diet; Get preventive screenings; and Make healthy choices (concerning alcohol, tobacco, drugs, and safety). HealthierUS is based on the premise that increasing personal fitness and becoming healthier is critical to achieving a better and longer life. To support this, President Bush signed an Executive Order ("Activities to Promote Personal Fitness") directing Federal agencies to review all prevention policies, programs, and regulations related to physical activity, nutrition, screenings, and making healthy choices. There is an intensive effort on the part of all federal agencies to identify on-going prevention programs/initiatives, propose revisions, modifications, or new actions to further improve the promotion of personal fitness in response to this Presidential order. The web address for the initiative is www.healthierUS.gov.

The VA National Center for Health Promotion and Disease Prevention has been designated the VHA representative and is actively participating in interagency meetings in this initiative. Any input or ideas in support of this Initiative from VA employees are welcomed. The points of contact at the Center are Steve Yevich, MD, MPH, phone (919) 383-7874, ext. 224 (www.steven.yevich@med.va.gov), and Richard Harvey, PhD, ext 227 (www.Richard.harvey3@med.va.gov)

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Hormone Replacement Therapy 2002 Controversy and Guidance

By Andrea S. Van Horn, CNP
Women Veterans Coordinator, Office of Ambulatory Care, VAMC Baltimore, MD

Currently, hormone replacement therapy (HRT) is approved by the Food and Drug Administration (FDA) for the treatment of vasomotor symptoms, urogenital atrophy and osteoporosis in post-menopausal women. The Post Menopausal Estrogen/Progestin Interventions (PEPI) Trial in the early 1990's, found HRT decreased the incidence of cardiovascular and Alzheimer's disease. The more recent Heart and Estrogen/progestin Replacement Study (HERS and HERS II) studies reported an increase in cardiovascular events and no effect on dementia.

The Women's Health Initiative, a study designed to study the long-term effects of combined estrogen plus progestin began in 1997 and is to end in 2005. The study focuses on the risks and benefits of the combined hormone replacement therapy on heart disease, breast and colorectal cancer and hip fractures in postmenopausal women. However, in May 2002, the data and safety monitoring board recommended stopping the randomized trial of estrogen plus progestin vs. placebo because the health risk exceeded health benefits over an average follow up of 5.2 years.

In this study after 5 years on the combined therapy, the risk of stroke increased by 41%, heart attack by 29%, cardiovascular disease by 22% and invasive breast cancer by 26%. Benefits included a reduction in colorectal cancer by 37% and hip fractures by 33%.

The U.S. Preventive Services Task Force (USPSTF) concluded that the harmful effects of estrogen plus progestin are likely to exceed the chronic disease prevention benefits in most women. They further suggested, the balance of benefits and harms for an individual woman will be influenced by her personal preferences, individual risks for specific chronic diseases and the presence of menopausal symptoms. The American Academy of Obstetrics and Gynecology (ACOG) agrees with USPSTF. Both sources clearly suggested that women and their providers discuss these issues together before making a decision to start, continue or stop hormone therapy.

The VA National Center for Health Promotion and Disease Prevention reviewed and concurred with the USPSTF recommendations. The Center noted that although the potential harms may be greater than the benefits for chronic disease prevention for most women, the differences are small and some women may choose to take hormone therapy, depending on their personal preferences. Effective strategies, other than HRT, for reducing risks for

fracture, heart disease, and cancer should be considered. Women who decide to take hormone therapy for menopausal symptoms, such as hot flashes, night sweats, or urogential symptoms, should use the lowest effective dose for the shortest possible time, with regular follow-up with their providers. Women who have had a hysterectomy and are taking Premarin should continue with that therapy. Study officials have not seen comparable risks in that population.

Primary Care providers should be aware of the new literature and recommendations for HRT in their female patients and refer to the women's health provider when necessary.

Resources include:

1. www.nchpdp.med.va.gov/ Home page.
2. www.acog.org Home page: "Questions and answers on hormone replacement therapy"
3. www.ahcpr.gov/clinic/uspstfix.htm Home page: "Hormone replacement therapy"
4. Writing Group for the Women's Health Initiative Investigators. Risks and benefits of estrogen plus progestin in healthy postmenopausal women: principal results from the women's health initiative controlled trial (WHI). *JAMA* 2002; 288(3): 321-33.

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Update on Chiropractic Care in VHA

By Sara McVicker, RN, MN, *Clinical Program Manager*
Office of Primary and Ambulatory Care, VA Central Office, Washington, DC

P.L. 107-135, the Department of Veterans Affairs Health Care Programs Enhancement Act of 2001, Section 204 requires VA to "carry out a program to provide chiropractic care and services to veterans through Department of Veterans Affairs medical centers and clinics." The legislation specifies:

- The Secretary shall designate at least one site for such program in each geographic service area of the Veterans Health Administration.

- The chiropractic care and services available under the program shall include a variety of chiropractic care and services for neuro-musculoskeletal conditions, including subluxation complex.
- The Secretary shall carry out the program through personal service contracts and by appointment of licensed chiropractors in Department medical centers and clinics.
- As part of the program, the Secretary shall provide training and materials relating to chiropractic care and services to Department health care providers assigned to primary care teams for the purpose of familiarizing such providers with the benefits of chiropractic care. The legislation also requires establishment of a Chiropractic Advisory Committee that "will provide direct assistance and advice to the Secretary of Veterans Affairs in the development and implementation of the chiropractic health program. Matters on which the Committee shall assist and advise the Secretary shall include:

  - Protocols governing referrals to chiropractors;
  - Protocols governing direct access to chiropractic care;
  - Protocols governing scope of practice of chiropractic practitioners;
  - Definitions of services to be provided; and
  - Such other matters as the Secretary determines to be appropriate."

Until the administrative steps necessary for hiring doctors of chiropractic or contracting for chiropractic care at VA sites are completed, VHA Directive 2000-014 remains in effect. Chiropractic care is available to enrolled veterans through the fee basis program upon referral by a VA clinician.

The Chiropractic Advisory Committee has been chartered and members appointed. Members are:

Chair:

Reed B. Phillips, DC, MSCM, PhD, DACBR is President, Los Angeles College of Chiropractic, Southern California University of Health Sciences. He is also President of the Council on Chiropractic Education and serves on the Department of Defense Chiropractic Health Care Demonstration Oversight Advisory Committee. He served in the Utah National Guard Special Forces as a medical specialist.

Members:

Charles E. DuVall, Jr., DC, MPS, CFE is in private practice in Akron, OH and is an independent forensic medical examiner and consultant. A veteran of the US Navy, Dr. DuVall served in Vietnam as a combat medic with the US Marine Corps.

Leona Marie Fischer, BS, DC of Elmhurst, IL was previously in private practice in Adairsville, GA. A veteran of the US Navy, Dr. Fischer served as a corpsman with the Special Operations EOD group in Virginia Beach, VA. Dr. Fischer is also a nationally certified Emergency Medical Technician as well as a nationally certified massage therapist. She is a member of the International Board of Governors, World Chiropractic Alliance.

Warren A. Jones, MD, FAAFP of Jackson, MS is Clinical Professor of Family Medicine, University of Mississippi Medical Center and Deputy Director of the Mississippi Area Health Education Centers. Before retiring from the US Navy Medical Corps, his last assignments were as Medical Director, TRICARE Management Activity and Special Assistant to the Surgeon General for Physical Qualifications and Review, Department of the Navy.

Michael S. McLean, DC, FICA is in private practice in Virginia Beach, VA. He is qualified as an Accreditation Official for the Council on Chiropractic Education and is postgraduate faculty, Life College of Chiropractic. He is a Director of the International Chiropractors Association and serves as ICA Legislative Chair. Dr. McLean served in the US Navy Reserve.

Rick A. McMichael, DC, FICC. is in private practice in Canton, OH. A member of the American Chiropractic Association, he was one of the first six doctors of chiropractic in Ohio to be granted hospital privileges. He is also past Chairman of the Committee on Fraud for the Federation of Chiropractic Licensing Boards, Past President of the Congress of Chiropractic State Associations, and serves on the Department of Defense Chiropractic Health Care Demonstration Oversight Advisory Committee.

Brian P. Murphy, MPT is Clinical Manager, Rehabilitation, VA Salt Lake City Healthcare System and Chair of the VHA Physical Therapy Advisory Council. He is also a member of the VHA Physical Medicine and Rehabilitation Field Advisory Board and Clinical Instructor and Faculty member, University of Utah, Division of Physical Therapy. Mr. Murphy is also President of the VA Section, American Physical Therapy Association and an Army veteran.

Michael K. Murphy, DO, FACOFP is Executive Director of Appalachian Osteopathic Postgraduate Training Institute Consortium, Pikeville College, School of Osteopathic Medicine; Professor of Family Medicine at Pikeville College, School of Osteopathic Medicine; and Director of Medical Education, Family Practice Program Director, Pikeville Methodist Hospital, Pikeville, KY. A veteran of the US Navy, Dr. Murphy was the US Navy Surgeon General Advisor on Osteopathic Medicine and the Surgeon General's Liaison to the Department of Defense Chiropractic Health Care Demonstration Project.

Michael J. O'Rourke, of Washington, DC is Assistant Director, Veterans Health Policy, and National Veterans Service for the Veterans of Foreign Wars of the United States. Mr. O'Rourke served in the US Marine Corps, including a tour in Vietnam. He later was commissioned after attending the Naval School of Health Sciences Physician Assistant Program.

Paul Gordon Shekelle, MD, PhD is Staff Physician, West Los Angeles VAMC and Associate Professor of Medicine, University of California, Los Angeles. He is also Director, Southern California Evidence-Based Practice Center; is a Consultant, with the Health Sciences Program, RAND; and serves as faculty for the Robert Wood Johnson Clinical Scholars Program, UCLA.

Cynthia S. Vaughn, DC, FICC is in private practice in Austin, TX. She was appointed to the Texas Board of Chiropractic Examiners in 1997 and has served as the President since May 2000. She is the Texas State Delegate to the National Board of Chiropractic Examiners and the Federation of Chiropractic Licensing Boards.

The Committee held its first meeting September 23-25, 2002 in Washington, DC. Following a brief meeting with Secretary Principi, the Committee received an orientation to VA, including human resource and credentialing and privileging procedures. The Committee then developed a plan of work to accomplish their charges and began discussion on qualification standards.

The next meeting will be December 4-5, 2002. As a federal advisory committee, meetings are open to the public and written statements may be submitted to the Committee at any time. Details of meetings and topics to be discussed are contained in Federal Register notices which will be published at least 15 days prior to each meeting. Information on meetings will also be available on the Primary and Ambulatory Care internet site (http://www.va.gov/primary/) or from the Committee Manager, Sara McVicker, RN, MN, Clinical Program Manager, Office of Primary and Ambulatory Care, VA Central Office, (202) 273-8558.

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Speech Recognition:

By Stephen C. Ezeji-Okoye, MD

ACOS, VA Medical Center, Palo Alto, CA

I have been using speech recognition to create my outpatient clinic notes for the past year. I believe that it is a viable alternative to both dictation and typing of notes.

The main advantage of dictation is that it is quick and easy. Providers can talk as quickly as they like and do not have to worry about spelling and punctuation. There are several disadvantages. Notes are not immediately available. Turnaround time may be as long as days to weeks. Notes need to be edited to ensure accuracy, which adds to the overall time to complete the note. Editing can be difficult if key words or phrases are left blank or are not easy to recreate e.g. med lists. Not editing notes can lead to inaccurate or incomplete records. If notes are needed immediately a hand written note must also be generated leading to increased work. e.g. transferring a patient to an outside ER or when writing an operative or procedure note. Cost is also a barrier. Current dictation cost is 16.5 cents/line. Dictation lends itself to longer notes; an average primary care note can cost $10.00. For a primary care provider seeing 15 patients a day yearly cost could exceed $30,000.

The main advantage to typing notes is that they are immediately available, templates can be used and there is no additional outlay of funds. The disadvantages are that many providers are not skilled typists and it may take more provider time to create a note. This often leads to very short notes that are full of abbreviations and can be difficult to follow, or cutting and pasting of old notes to create new notes. The latter lends itself to charges of fraud if work that was not done in a particular visit is included in the note, and to notes that look very similar from one visit to the next.

Speech recognition is somewhere between dictation and typing in its advantages and disadvantages. It is relatively easy to use. It requires an initial training session to create an acoustic reference file and then ongoing tweaking to adjust pronunciation and add words to improve accuracy. I am able to achieve about 95% accuracy without having done much adjustment to my acoustic reference file. Because of having to add punctuation and having to speak clearly you cannot speak as fast as you can in dictation, but can speak at a regular talking pace. Also, you must remember to add punctuation. This leads to a slightly longer dictation time than ordinary dictation. However, as the dictation appears in real time it is much easier to edit, and it is much easier to add sections or comments if you have forgotten to put them in as you were dictating. I believe that when dictation time and editing time are combined I am saving 25% of the time I was spending dictating and then later editing my notes. Also as notes are immediately available when I am finished dictating I am finished with my note, and I avoid duplication of work if a note must be immediately available. In addition, it is clinically very valuable to have immediate access to the whole medical record. This is especially true of settings like urgent care or the ER. Speech technology can be used with existing VA templates and can have templates of its own which improve speed of note completion and accuracy. Because speech technology can be loaded on a server it is possible to have a person dictate from multiple sites and locations. In addition, this lends itself to the purchase of concurrent site licenses that are much cheaper than single stand-alone units. For most providers speech technology will be much faster than typing their notes. As the VA is already utilizing an electronic medical record the main cost for speech technology is in purchasing the software (microphones are included) and doing any necessary upgrades in RAM. The return on investment by a full time general medicine clinic provider is approximately 10 weeks.

We are in the process of expanding our speech recognition pilot to Radiology, General Surgery and the Emergency Room. We hope that this will enable providers to more

easily complete their documentation and will make this documentation more readily accessible to other providers.

* * *

VA Patients are Eligible for Referral to New War-Related Illnesses and Injury Centers (WRIISCs)

By Connie Raab, *Director Public Health Communications, Office of Public Health and Environmental Hazards, VA Central Office, Washington, DC*

VA health care providers sometimes see combat veterans with debilitating, but difficult-to-diagnose, illnesses. If so, help is available through referral of these patients to one of two new War-Related Illnesses and Injury Study Centers established by VA last year at the VA Medical Center in Washington, DC, and the VA Medical Center East Orange, New Jersey.

A newly published Information Letter released by the Under Secretary for Health provides information clinicians need to determine a veteran's eligibility for referral to a WRIISC. Veterans involved in combat are eligible, from World War II veterans through veterans returning from the ongoing war on terrorism in Afghanistan and surrounding countries.

The WRIISCs offer specialty care for combat veterans with difficult-to-diagnose, disabling illnesses. Other functions include research as well as education and risk communication for VA patients and their families and health care providers.

For more information, VA health care providers can check

- IL (Information Letter) 10-2002-018, "Patient Referral Eligibility for VA War-Related Illnesses and Injury Centers" - http://www.va.gov/publ/direc/health/infolet/10200218.pdf
- War-Related Illnesses and Injury Centers VA Intranet site - http://vaww.vhaco.va.gov/pubhealth/WRIISC.htm

or call the Environmental Agents Service (131), in Central Office's Office of Public Health and Environmental Hazards, at (202) 273-8579.

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The Elements of Electronic Note Style

By Eina G. Fishman, MD, MS, *Chief of Staff, VA Medical Center, Albany, NY*

(With apologies to William Strunk Jr. and E.B. White [The Elements of Style, 4th ed. Needham Heights: Allyn & Bacon, 2000]) Puget Sound Health Care system created these PEARLS of wisdom with regard to documentation in the electronic medical record. It can be found at the following address: http://vaww.puget-sound.med.va.gov/cprs/NewGUITutorial/rulea8
Writing notes in an electronic medical record is different from writing them on paper. Because it is new to most of us, we don't have a set of norms or rules that we all follow. Here is a listing of simple rules to consider as you write your next CPRS note.

1. Omit needless text
Succinct notes are more readable than verbose, lengthy tomes. Particularly troublesome are notes with long checklists that are not checked, through which the reader must wade to find positive or negative findings. If a section of a template doesn't apply to your patient, delete it. However don't delete required sections--see Rule 8 below.

2. Make sure the reader knows what you observed on history and physical, and does not confuse it with what another observer recorded at another time.
Your note is stamped with a date and time when you sign it. Unless you indicate otherwise, the reader will assume the findings you describe in your note were observed soon before you wrote your note. If you copy another history or physical into your note, it won't be clear to the reader that the copied findings were observed a day earlier or more. If you copy large volumes of text in a manner that implies you obtained the historical information or performed the physical exam yourself, you can create clinical, financial, and legal problems for your patient, yourself, and the institution.

3. Don't copy without attribution
Clear and intelligent discussion of a patient's problem within your assessment is a valuable contribution to the patient's care, and to understanding by other clinicians. Just as you should not plagiarize in scholarly writings, there is no place for plagiarism in the medical record.
Never copy the signature block into another note.
Signature blocks (see example below) are automatically generated when the author signs the note. Copying the signature block could confuse readers, who may think that the copied signature applies to the note into which it was pasted.

Signature blocks appear as below:

/es/ WILLIAM OSLER, MD
STAFF, INFECTIOUS DISEASE
Signed: 02/03/1998 14:34

4. Refer to laboratory findings, radiology reports, and other information in the record without copying it verbatim into your note.

Remember that readers can look up details elsewhere in the record if needed. "Chem 7 normal," or "path report from today shows squamous cell cancer" is sufficient for a progress note. The reader can view all 7 chemistry results with the normal range, or the pathologists complete report by looking elsewhere within CPRS.

5. Review and sign your notes promptly
Your note will not be available for others to view until you sign it. This is designed to protect other clinicians from taking action on the basis of a note that you are still writing and may change or delete. Once you have signed the note, you can add additional information in an addendum if needed.

6. Strive to make your note visually attractive
Proper use of headings, indentation, and other visual guides will make your note more readable and appear more professional. Remember that what you write today will remain in the record with your name attached to it for a very long time. This does not mean you need to spend hours dressing up your note instead of caring for your patient or learning, only that you should develop habits that improve the appearance of your note. You spent years learning penmanship; it's worth a few days or weeks learning how to type notes. See below for some examples of attractive notes.

7. Don't use abbreviations others may not understand
Don't assume readers know what ESRD (end stage renal disease), STHB (said to have been), or other abbreviations mean. A problem was identified in the CPRS spell checker and will be fixed with version 21 scheduled to come out in the next few months. This will allow you to quickly detect and expand abbreviations that you may have entered. Until such time that version 21 is activated the spell checker should be turned off. Find or develop note templates that suit your note.

8. When rules exist on the content or structure of a note, follow them
Examples of notes that have rules are Discharge Summaries, Preoperative Anesthesiology Notes, and Nursing Admission Assessments. The structure of these notes is governed by external reviewers such as JCAHO or by local VA Puget Sound policy.
Notes who's Structure is Determined by Rules
Examples of notes whose structure is determined by local or JCAHO rules are below. Follow the template structure and don't delete unchecked items on lists.

- Interim Summary
- Discharge Summary
- Nursing Admission Assessment Template
- Nursing Transfer Summary Template
- Nursing Discharge Summary Template
- Nursing Death Note Template

Rules For Discharge Summaries:
- Follow the template structure listed in the CPRS GUI Shared Templates drawer.
- Never use abbreviations in the diagnosis listing. For example, use Congestive heart failure instead of CHF.
- Elsewhere only use abbreviations you would find in Stedman's dictionary, which is available in the Library folder on your workstation. When in doubt, spell it out.
- Follow the template structure listed in the CPRS GUI Shared Templates drawer.

Rules For Nursing Templates:
Don't delete unchecked items.
Outpatient consultant progress note
Your note will not be available for others to view until you sign it. This is designed to protect other clinicians from taking action on the basis of a note that you are still writing and may change or delete. Once you have signed the note, you can add additional information in an addendum if needed.

SAMPLE NOTES:
Outpatient consultant progress note
XXXXXX is a XX year old man with multiple medical problems including prior subtotal gastrectomy for gastric cancer, CAD, PVOD s/p aortobifem and left fem-below knee pop who is followed in vascular clinic for multiple issues.
(1) Right renal artery occlusion and left renal artery s/p stent. His last creatinine was 1.0 on Oct 4. He states that his BP has been stable. He last had a renal artery duplex 1/20/00 which demonstrates >60% stenosis of his left renal artery. His right main renal artery is known to be occluded by angio. He is on 3 BP meds: atenolol, lisinopril, felodipine with a stable SBP 168-170.
(2) PVOD: Recent duplex 1/20/00 demonstrates patent graft with reverse flow throughout and no evidence of stenosis. AAI's were 0.64 on the right and 0.91 on the left. Previously, they were 0.54 on the right and 0.99 on the left. He states that he has 1 block pain in the thighs and calves that resolves with rest. He denies any rest pain or non- healing ulcers. He states claudication is not lifestyle-limiting.
(3) Bilateral 50-79% carotid artery stenosis: No symptoms of TIA or stroke.On examination, he has bilateral carotid bruits. His heart is regular without murmurs. He has bilateral palpable femoral pulses.
Impression:
(1) Stable renal artery stenosis: his velocities have not changed within the past 1-2 years looking back at old duplexes. His creatinine is stable, kidney size is stable. No indication for intervention. Re-duplex in 6 months.
(2) PVOD: Stable. No indication for surgery currently.
(3) Carotid stenosis bilaterally: No indication for surgery. Continue surveillance duplexes.
/es/ XXXXXXXXXX
RESIDENT
Signed: 01/25/2000 08:41

Inpatient progress note
ACTIVE MEDICATIONS
ACETAMINOPHEN TAB 650MG PO Q4-6H PRN for pain or fever
ALUMINUM/MAGNESIUM HYDROXIDE/ 30CC PO Q6H PRN
CALCIUM CARBONATE TAB,CHEWABLE 2 tabs PO QD
DOCUSATE CAP,ORAL 250 mg PO BID
HALOPERIDOL TAB 1mg PO Q4-6H PRN q 4-6 hours for agitation
LANSOPRAZOLE CAP,SA 30mg PO QD
LEVOTHYROXINE TAB 0.1 mg PO QD
MAGNESIUM HYDROXIDE SUSP 30CC PO QD PRN for constipation

MINERALS/MULTIVITAMINS TAB two tabs PO QD
NITROGLYCERIN TAB,SUBLINGUAL one tab SL PRN chest pain
SODIUM BIPHOSPHATE/SODIUM PHOSPHATE 1 enema PR QD PRN if no BM X 3 days
SULFACETAMIDE SOLN,OPH one drop OU Q3HRS
VITAMIN E CAP,ORAL one tab PO QD

EVENTS OVERNIGHT: Crosscover intern called to see pt re SOB. Apparently on exam he was wheezing, using his accessory muscles. On auscultation poor air movement. After the first neb, he had coarse crackles b/l lung bases. O2 sat 97%, BP 160s/90s, EKG showed no new changes, ABG 7.38/36/94/21/97% CXR showed increased vascular markings consistant with fluid overload. He was given Lasix 40mg IV and IVF d/c'd, Haldol also given.
SUBJECTIVE This am pt without complaints. No SOB, no CP
OBJECTIVE:
VITAL SIGNS
Temp: 96.5 (08/28/1999 16:00) Pulse: 69 (08/28/1999 16:00) Resp: 18 (08/28/1999 16:00) BP: 144/82 (08/28/1999 16:00 Ht: 67 (07/24/1997 13:30) Wt: 178.42 (08/28/1999 04:00)

General: Pt alert, oriented x2, in NAD HEENT: left pupil in tear drop shape, pupils reactive bilaterally oropharynx clear Neck: supple, no LA Lungs: bibasilar crackles increased today CV: RRR without murmur Abd: nondistended, +BS, soft, NT, no hepatomegaly Ext: no edema Back: no CVA tenderness neuro: CN 2-12 intact, strength 5/5 B
LABS: 4.2 \ 13.4 /168 143 | 105 | 58 / 96 Ca=8.3
Mg=1.7 PO4=4.9/ 39.8 \ 4.8 | 24 | 2.8 \
UA - 1+bld, no casts
Renal US performed by radiologist prelim report: no hydronephrosis (final report pending)
A/P: 77 yo male with dementia transferred from Harborview hospital for further work up of ARF likely secondary to hypotensive event causing ATN
Urine sediment with many granular casts, tubular epithelial cells
Creatinine improving
-Heplock IVF due to evidence of volume overload last pm
-Monitor I/O's
-Monitor lytes
-Low K diet
-Renal following
/es/ Bill Osler, MD

Primary care outpatient progress notes
Problem: gout
Subj: He has had 3 episodes of gout in the last 6 months involving his feet. They have been treated with colchicine bid with good results
Obj: wt 252 HR 48 BP 108/58
no gout now on examination; his uric acid is 10.7
Assess: gout
Plan:
1) BEGIN ALLOPURINOL 300MG QD
2) COLCHICINE ONE TABLET QD for first few weeks of ALLOPURINOL
/es/ XXXX XXXXXXX
Attending
Signed: 01/30/1999 17:14

Another outpatient progress note:
PROBLEM LIST:
1. LBP--Repetitive injuries (MVA, fall) 1994-6, developed severe LBP with sciatica (R) 9/96. Disabled pt., quit work. Per pt., dx'd at HMC with L4-5 herniation. Pain is constant, flares q few months. Pt in w/c when pain flares, unable to fully extend. Minimal relief with methocarbamol, next to none with NSAID's and tylenol. Some relief with opiates (tyco, percocet) in past. No perceived benefit from PT, exercises. Never tried alternative tx. Not interested in surgery 2 to evidence of lack of effectiveness
2. Hypothyroidism
3. Hepatitis C
4. H/O Etoh dependence
5. Depression
MEDS LEVOTHYROXINE 0.15QD, LANSOPRAZOLE, MAALOX, SERTRALINE, METHADONE 15 Q6, ATENOLOL 50 QD, PSEUDOFED beclovent nasal.

S:
41:yo man RTC for routine f/u. Reports that LBP in much better control on methadone, followed by pain clinic. Now c/o some tingling and numbness in R thumb, index and middle finger w/o assoc weakness, or numbness in arm. Also voices ongoing concerns with rhinorrhea, using nasal steroids and pseudofed. O:HR 64 BP 104/64, Neuro: focal numbness in thumb, 2nd and 3rd digit on right hand, 5/5 strength throughout, no areas of sensory change on arm. +phalen's, neg. Tinel's
ASSESSMENT
1. LBP--much improved pain control on methadone. Followed by pain clinic.
2. Hypothyroidism--no clinical evidence of hypo/hyperthyroidism, followed by Endocrine.
3. Hep C--continues to have LFT elevations with reported d/c of ETOH GI clinic deferring rx until Etohism and depression in long term control.
4. BP--cont atenolol.
5. Finger numbness - possible CTS, no radicular sx's. Ibuprofen 800 TID and wrist brace. If no improvement, consider EMG.
6. Allergic rhinorrhea - start fexofenadine, cont. beclovent nasal.
7. f/u in 4 mos.
/es/ XXXX XXXXXXX
resident
Signed: 06/30/1999 17:14:

* * *

2003 VA Epidemiology Distance Learning/Cyber Sessions

By Carrie L. McCloud, CPS
VA Puget Sound Health Care System, Seattle, WA

The VA Epidemiology Distance Learning/Cyber Courses are directed by the VA Epidemiologic Research and Information Centers, Cooperative Studies Program, VA Office of Research and Development, Department of Veterans Affairs. These courses were offered during the 2002 Summer Epidemiology Session on the University of Washington Campus, Seattle, WA.

To participate in the distance learning/cyber course you will need to register at http://vaww.ees.aac.va.gov/eric, secure time away from work to watch the courses at your VA, complete the daily readings and homework, and order the course textbooks. The classes are either 2 or 2 ½ hours/day and begin at 1PM EST. Please allow an additional hour per day for course reading and homework.

Fees: None. The only cost is the purchase of textbooks.
Registration Process: Go to http://vaww.ees.aac.va.gov/eric to register or for more information.

Distance Learning/Cyber Objectives

- To provide state-of-the art information on epidemiology and research methods to VA professionals working in administrative, clinical and research areas.
- To provide VA relevant examples to illustrate the application of concepts.

Courses

Cost and Outcomes Research – **Dates:** February 3 – 7, 2003

Faculty: Sean Sullivan, PhD Professor of Pharmacy, Director of the Pharmaceutical Outcomes Research and Policy Program and Co-Director of the Center for Cost and Outcomes Research, University of Washington; David Veenstra, PhD, PharmD, Assistant Professor of Pharmacy, University of Washington.

Course Objective: To provide theory, methods, tools and applications of outcomes research and cost-effectiveness analysis of health care services and programs.
Content:

- Taxonomy and critical assessment of effectiveness and outcomes studies
- Cost analysis and preference assessment
- Cost effectiveness and cost benefit analysis
- Clinical states, functional health and QOL
- Use of questionnaires, scales and indices
- Use of effectiveness and outcomes data

Clinical Trials – **Dates**: February 18 – 21, 2003

Faculty: William Henderson, PhD former Director of the Hines Cooperative Study Center and Visiting Professor, Health Outcomes Program, University of Chicago; Domenic Reda, PhD Acting Director of the Hines Cooperative Studies Center.

Course Objective: To provide theory and application on the design, conduct and analysis of clinical trials.
Content:

- Defining research hypothesis and components
- Basic designs
- Choosing study subjects
- Interventions and endpoints
- Planning data collection
- Statistical inference, sample size, and power
- Issues in data analysis
- Publishing the trial

General Biostatistics **–Dates:** February 10 – 14, 2003

Faculty: Marie Diener-West, PhD, Professor of Biostatistics at Bloomberg School of Public Health, Johns Hopkins University. Dr. Diener-West has received the Golden Apple Award for Excellence in Teaching on four occasions.

Course Objective: To provide an introduction to the concepts and application of biostatical methods.

Content:

- Overview of biostatistics
- Descriptive statistics
- Hypothesis testing and p-values
- Confidence intervals
- Common statistical tests
- Sample size and statistical power
- Introduction to simple regression analysis

For questions about continuing education please contact: Anne Toothaker, Nurse Planner, Employee Education System Boise Center (14A), 500 West Fort Street, Boise, ID 83702, Phone: (208) 422-1305, Fax: 208-422-1377.

For questions about the course or if you require assistance with special learning needs: please contact the Seattle ERIC at email eric@med.va.gov or Gayle.Reiber@med.va.gov.

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Monthly Primary Care Conference Calls

Conference calls are scheduled for the third Wednesday of each month at 1:00 P.M., ET. Dial in number is 1-800-767-1750; the access code is 28097. The next call is scheduled for December 18, 2002.

Dates in 2003 are:

January 15	July 16
February 19	August 20
March 19	September 17
April 16	October 15
May 21	November 19
June 18	December 17

Schedule for MAP articles

FLOW	1st Q/2003			2nd Q/2003			3rd Q/2003			4th Q/2003		
	Oct	Nov	Dec	Jan	Feb	March	April	May	June	July	Aug	Sept
Articles Submitted	18			17			18			18		
Distribute to Board Members		15			7			9			8	
Comments to OPAC			3		21				4		29	
Final Presentation to 112			17			7			18			10
Electronic & Hard Copy Distribution			20			19			25			17

Website http://vaww.va.gov/primary

Articles may be submitted electronically at any time to Mildred Eichinger and/or Renee Hodges.

MAP

We welcome your articles related to any current Issues in the area of healthcare in general or specifically in the field of ambulatory and primary care. Contact Mildred Eichinger at 202-273-8552 or Renee Hodges at 202-273-8558 if you have any questions.

HAPPY HOLIDAYS TO YOU AND YOURS!